State of Rhode Island
MUTUAL AGREEMENT

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No. _____

1. EMPLOYEE INFORMATION:

SSN _____
Name _____
Address _____
City, State, Zip _____
Phone _____

2. CLAIM INFORMATION:

Employer _____
Insurance Co. _____
Claim Administrator _____
Injury date _____
Incapacity date _____

This form may be used pursuant to Rhode Island General Law § 28-35-6(b) to amend a Memorandum of Agreement, Order or Decree regarding a Workers' Compensation claim. This form cannot be used for commencement or termination of weekly benefits.

YOU *MUST* ATTACH A COMPLETED REPORT OF INDEMNITY PAYMENT (DWC-22) TO THIS MUTUAL AGREEMENT.

3. INDICATE THE ACTION(S) OF THIS MUTUAL AGREEMENT:

☐ Change total average weekly wage from $ _____ to $ _____
☐ Change weekly spendable base wage to $ _____ as of _____ (date)
☐ Change weekly compensation rate to $ _____ as of _____ (date)
☐ Change marital status to ☐ Single ☐ Married as of _____ (date)
☐ Change maximum number of exemptions to _____ as of _____ (date)
☐ Change number of dependents to _____ as of _____ (date)
☐ Change nature of injury and/or affected body part to _____
☐ Modify from total to partial incapacity as of _____ (date)
☐ Modify from partial to total incapacity as of _____ (date)
☐ Suitable Alternative Employment (Attach SAE Offer) as of _____ (date)
☐ Other (Specify) _____

_____

_____

DO NOT USE THIS FORM FOR A SPECIFIC INJURY (DISFIGUREMENT, LOSS OF USE, HEARING LOSS); USE THE REPORT OF SPECIFIC PAYMENT (DWC-51).

Employee Signature:	Date:	Employer/Insurer Signature:	Date: